ADDRESSING ALL NEEDS: HOW TO ASSIST CLIENTS IN OBTAINING AND MAINTAINING PRIMARY HEALTH CARE IN THEIR NEW NEIGHBORHOOD

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- OPCC is a community-supported organization in which staff, volunteers and clients work together with mutual respect to address the effects of poverty, abuse, neglect and discrimination. The agency's programs are designed to empower people to access the resources they need to ensure their survival, end their victimization and improve the quality of their life.
- OPCC is committed to empowering those we serve to rebuild their lives and overcome mental illness, poverty, domestic violence, and homelessness.

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- Housing Outcomes
  - Last year, OPCC assisted over 1,800 individuals including families with children to obtain emergency housing or transitional housing. Due to the efforts of staff, volunteers and community partnerships, 268 individuals and families were successful in securing permanent housing in apartments throughout the region. This represents a 31% increase in OPCC's housing placement rate from the previous three years.
  - **During the past thirteen years OPCC has developed one of the most successful housing programs in the nation with a housing retention rate of 90 - 94% annually.**

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Services Provided

- Case Management
- Mental Health Services
- Primary Health Care

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Case Management Services

- Move-in set up and assistance
- Emotional support
- Referral to community resources
- Basic needs services, including grocery, transportation and financial grant assistance
- Housing Authority and Landlord liaison
- Crisis intervention
- Goal identifying, planning and problem solving

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Mental Health Services

- Short term therapy with on staff clinicians
- Mental health assessments
- Crisis intervention
- Connection to emergency psychiatric facilities
- Psychiatric services with on staff psychiatrist
- Outside referrals to mental health agencies for long term therapy and psychiatric needs

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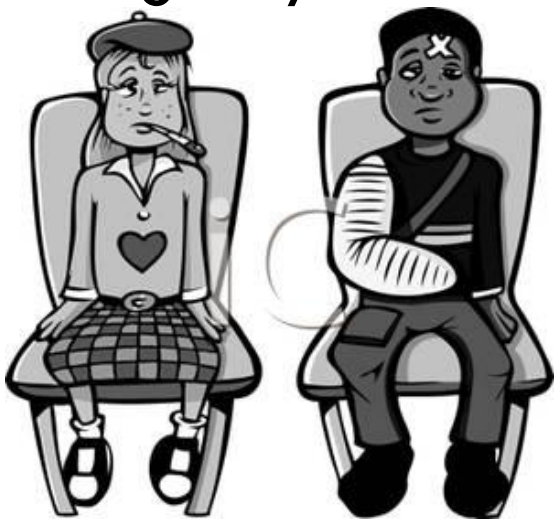
Primary Health Care- Why is it important?

- Consistency in care
- Relationship building
- Maintenance of chronic conditions
- Routine medication management
- Decreases utilization of emergency services



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Why is Primary Health Care Important?

- Local area medical home can cut travel time and expenses
- Provides a “new start” away from the street
- Orients one to their new community and resources available to them

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What are Some Barriers to Care?

- Mental Health
  - Untreated mental illness, including paranoia, anxiety etc.
- Distrust of systems
- Fear
- Substance Use
- Stigma
- Ambivalence
- Lack of education and knowledge
- Health not being a priority

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Making a Smooth Transition

- Transitions taking place
  - From homelessness to housing
  - Into a new community
  - Connecting to new services, including physical and mental health
- Ways to ease transition
  - Timing can be everything
  - Frequent check ins and home visits
  - Accompanying the client to their “firsts”
  - Researching the area together
  - Creating maps together

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Health Care Collaboration

- Making Connections
  - Community collaboration meetings with other social service agencies and health centers
  - Introductions
  - Schedule facility tours
  - Educate yourself on agencies in the housed clients area
  - Warm handoffs

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Health Care Collaboration

- Types of agencies
  - Social service agencies
  - Hospitals
  - Mental health centers/psych ERs
  - Day centers
  - Primary care facilities
  - Substance use treatment programs
  - Police
  - Fire
  - Shelters

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Understanding Insurance

- HWLA (HealthyWay LA)
- Medi-cal Full Scope
- Medi-cal Managed Care

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Cooperative Health Care for the Homeless Network (CHCHN)

- CHCHN has worked with homeless healthcare partners to provide medical care, dental care, case management, behavioral health care services, alcohol/substance abuse treatment and outreach to those in need, regardless of their ability to pay for services.
- The 14 health care agencies that make up the CHCHN provide complete health care services to at least 41% of the LA County homeless population at several sites throughout the county.

Cooperative Health Care for the Homeless Network (CHCHN)

- San Fernando Valley
  - Northeast Valley Health Corporation
- Westside Los Angeles
  - Venice Family Clinic
- South Los Angeles
  - Central City Community Health Center
- East Los Angeles
  - Clinica Msr. Oscar Romero Community Health Center
  - City Help, Inc.

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Cooperative Health Care for the Homeless Network (CHCHN)

- Hollywood
  - The Saban Free Clinic
  - Childrens Hospital Los Angeles- High Risk Program
- Downtown Los Angeles
  - JWCH Center for Community Health
  - UCLA School of Nursing at the Union Rescue Mission
  - UCLA School of Dentistry at the Union Rescue Mission
  - Homeless Health Care Los Angeles

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Cooperative Health Care for the Homeless Network (CHCHN)

- Pasadena
  - Community Health Alliance of Pasadena
- Long Beach
  - The Children's Clinic
- West Covina
  - East Valley Community Health Center

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Other Community Health Centers

- Tarzana Treatment Center
- Les Kelly Clinic
- Watts Health Center

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Breakout Session

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Discussion

Scenario #1

- Client is a 51 year old male previously housed in 2008. Housing has been maintained since 2008 with one change in location. He has received case management services with one home visit per month. Client has been able to care for self, maintain his unit, pay rent and all bills when on psych medication. Since 2008, client has stopped taking psych medication a couple times per year resulting in a rapid decline in the ability to care for his unit and himself. Client experiences visual hallucinations and hears voices as well as suffers from extreme depression and a severe eating disorder. Client has also been on high doses of methadone maintenance for over 10 years and has recently decided to take himself off of all medications including his methadone. He has disconnected from mental health services and does not have a primary care physician.

- How can you best help this client connect to much needed mental health and medical services?
- How can you maintain this clients housing?

Scenario #2

- Client is in his mid 50's with a 12 year homeless history. He has a history of head trauma with brain injury. Due to the brain injury, history of bipolar and anxiety disorder, he has extreme paranoia—especially regarding systems. He has no interest in mental health services, including therapy and psychiatry. He has been a very high utilizer of Emergency Room services—going to the ER 1-2 times per week, for chronic medical conditions and for prescriptions for Ativan and Norco. Now in housing for almost a year, client struggles to accept primary medical care. When he meets a new potential primary care provider (PCP), he immediately fears that they are "secret psychiatrists" trying to push psych medications on him. Client will not see a psychiatrist for his anxiety disorder to receive an Ativan prescription, and will not see a physician who does not prescribe what he wants. He still frequents the ER, but will agree to meeting new PCPs. When he meets them, he continues the pattern of pushing them away.

- How can you best help this client connect to much needed mental health and medical services?
- Do you believe his housing is at risk?

Questions?

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